STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs
Maryland Department of Health and Mental Hygiene
Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

MEMORANDUM

TO: Nursing Facility Administrators

FROM: Jane Sacco, Chief
Division of Long Term Care Services

SUBJECT: Quality Assessment Reporting and Payment – FY 2017

DATE: August 31, 2016

The purpose of this memo is to provide information regarding the requirements for quality assessment reporting and payment for Fiscal Year 2017. As in previous fiscal years, the Medicaid Program is using electronic reporting and payment methodologies.

For FY 2017, the assessment amount is $25.00 for all facilities subject to Quality Assessment, except for the five facilities that reported the most Medicaid days of care for FY 2015. For those five facilities, the assessment amount is $5.50.

Reporting Days of Care

Facilities shall report applicable days of care using the electronic format designated by the Program. Copies of the formats with instructions for completion are attached. Please note that the formats have been modified to enable facilities to report adjustments from prior fiscal years. Also, in the format that is used for all but the top five Medicaid facilities, the format no longer contains a drop-down box with the list of facilities; this enables new facilities and those with recent changes of ownership or name change to use this form. The forms and instructions are also available for download at (scroll to bottom of page):

https://dhmh.maryland.gov/longtermcare/Nursing%20Facility%20Documents/Forms/AllItems.aspx?RootFolder=%2Flongtermcare%2FNursing%20Facility%20Documents%2FQuality%20Assessment%20Reporting%2FFY17%20Quality%20Assessment

Reports shall be submitted via e-mail to dhmh.qualityassessments@maryland.gov. The subject line shall contain the following:

(Facility Name) – FY 2017 – Quarter (#)

Please note that reports must be submitted no later than 60 days following the last day of the quarter being reported, i.e. 11/29/16, 3/1/17, 5/30/17, and. 8/29/17. Facilities that fail to submit reports by the deadline are subject to suspension of Medicaid payments.

201 W. Preston Street – Baltimore, Maryland 21201
Toll Free 1-877-4MD-DHMH – TTY/Maryland Relay Service 1-800-735-2258
Web Site: www.dhmh.maryland.gov

August 31, 2016

Remitting Payments

Payments shall be made using either ACH transfer or wire transfer. Directions for completing transfers are as follows:

ACH Transfer - The State Treasurer's office requires that the following information be included in the ACH record file as follows:

- Nacha A6-5" field should contain the Bank Account Number 003933342489
- Nacha A6-7" field should contain the facility's nine digit Medicaid number
- Nacha A6-8" field should contain T309S

All ACH transfers should be sent to: Bank of America – Routing # 052001633, Bank of America, 100 S. Charles Street, Baltimore Maryland 21202.

Wire Transfer – Necessary information for wire transfer is below:

- Bank Indentifier (ABA#):026009593
- Bank Account #: 003933342489
- Bank Address: Bank of America, 100 West 33rd Street, New York, NY 10001

Please include the facility's name, provider #, and the fiscal year and quarter to which the payment belongs. This information is especially necessary if a parent or management company is making the payment on behalf of the facility.

Thank you very much for your cooperation. Questions regarding completion of the report may be directed to Marquis Finch, Administrative Supervisor, at (410) 767-3533 or marquis.finch@maryland.gov. Questions regarding payment remittance may be directed to Mr. Afonagnon (Amen) Azondekon at (410) 767-5770 or at afonagnon.azondekon@maryland.gov.

Attachments

cc: Nursing Home Liaison Committee

NURSING FACILITY QUALITY ASSESSMENT PAYMENT REPORTING FORM

This form is to be used by facilities that are subject to the Quality Assessment at the rates of $25.00 per patient day

FACILITY NAME:
FACILITY PROVIDER #:
CONTACT PERSON/PHONE#:
TOTAL NUMBER LICENSED BEDS:

1ST QUARTER FY 2016

	July 2016	August 2016	Sept 2016	TOTALS
Total Patient Days				0
Less Medicare A Days				0
Less Medicare C Days				0
Prior Qtr Adjustments @ Current Rate				0
Total Assessed Days	0	0	0	0
Current Per Diem Rate	$ 25.00	$ 25.00	$ 25.00	$ 25.00
Subtotal Payment Amount	$ -	$ -	$ -	$ -
Adjustments from Previous Fiscal Years - please use worksheet titled "DetailPriorFY".				$ -
Total Payment Due				$ -

REPORT AND PAYMENT DUE BY 11/29/2016

QUARTERLY PAYMENT AMOUI

COMMENTS:

2ND QUARTER FY 2016

	Oct 2016	Nov 2016	Dec 2016	TOTALS
Total Patient Days				0
Less Medicare A Days				0
Less Medicare C Days				0
Prior Qtr Adjustments @ Current Rate				0
Total Assessed Days	0	0	0	0
Current Per Diem Rate	$ 25.00	$ 25.00	$ 25.00	$ 25.00
Subtotal Payment Amount	$ -	$ -	$ -	$ -
Adjustments from Previous Fiscal Years - please use worksheet titled "DetailPriorFY".				$ -
Total Payment Due				$ -

REPORT AND PAYMENT DUE BY 3/1/2017

QUARTERLY PAYMENT AMOUI

COMMENTS:

3RD QUARTER FY 2016

	Jan 2017	Feb 2017	March 2017	TOTALS
Total Patient Days				0
Less Medicare A Days				0
Less Medicare C Days				0
Prior Qtr Adjustments @ Current Rate				0
Total Assessed Days	0	0	0	0
Current Per Diem Rate	$ 25.00	$ 25.00	$ 25.00	$ 25.00
Subtotal Payment Amount	$ -	$ -	$ -	$ -
Adjustments from Previous Fiscal Years - please use worksheet titled "DetailPriorFY".				$ -
Total Payment Due				$ -

REPORT AND PAYMENT DUE BY 5/30/2017

QUARTERLY PAYMENT AMOUI

COMMENTS:

4TH QUARTER FY 2016

	April 2017	May 2017	June 2017	TOTALS
Total Patient Days				0
Less Medicare A Days				0
Less Medicare C Days				0
Prior Qtr Adjustments @ Current Rate				0
Total Assessed Days	0	0	0	0
Current Per Diem Rate	$ 25.00	$ 25.00	$ 25.00	$ 25.00
Subtotal Payment Amount	$ -	$ -	$ -	$ -
Adjustments from Previous Fiscal Years - please use worksheet titled "DetailPriorFY".				$ -
Total Payment Due				$ -

REPORT AND PAYMENT DUE BY 8/29/2017

QUARTERLY PAYMENT AMOUI

COMMENTS:

TOTAL STATE FY 2017 QUALITY ASSESSMENT $ -

NURSING FACILITY QUALITY ASSESSMENT PAYMENT REPORTING FORM

This form is to be used by facilities that are subject to the Quality Assessment at the rates of $5.50 per patient day

FACILITY NAME:
FACILITY PROVIDER #:
CONTACT PERSON/PHONE#:
TOTAL NUMBER LICENSED BEDS:

1ST QUARTER FY 2016

	July 2016	August 2016	Sept 2016	TOTALS
Total Patient Days				0
Less Medicare A Days				0
Less Medicare C Days				0
Prior Qtr Adjustments @ Current Rate				0
Total Assessed Days	0	0	0	0
Current Per Diem Rate	$ 5.50	$ 5.50	$ 5.50	$ 5.50
Subtotal Payment Amount	$ -	$ -	$ -	$ -
Adjustments from Previous Fiscal Years - please use worksheet titled "DetailPriorFY".				$ -
Total Payment Due				$ -

REPORT AND PAYMENT DUE BY 11/29/2016

QUARTERLY PAYMENT AMOUN

COMMENTS:

2ND QUARTER FY 2016

	Oct 2016	Nov 2016	Dec 2016	TOTALS
Total Patient Days				0
Less Medicare A Days				0
Less Medicare C Days				0
Prior Qtr Adjustments @ Current Rate				0
Total Assessed Days	0	0	0	0
Current Per Diem Rate	$ 5.50	$ 5.50	$ 5.50	$ 5.50
Subtotal Payment Amount	$ -	$ -	$ -	$ -
Adjustments from Previous Fiscal Years - please use worksheet titled "DetailPriorFY".				$ -
Total Payment Due				$ -

REPORT AND PAYMENT DUE BY 3/1/2017

QUARTERLY PAYMENT AMOUN

COMMENTS:

3RD QUARTER FY 2016

	Jan 2017	Feb 2017	March 2017	TOTALS
Total Patient Days				0
Less Medicare A Days				0
Less Medicare C Days				0
Prior Qtr Adjustments @ Current Rate				0
Total Assessed Days	0	0	0	0
Current Per Diem Rate	$ 5.50	$ 5.50	$ 5.50	$ 5.50
Subtotal Payment Amount	$ -	$ -	$ -	$ -
Adjustments from Previous Fiscal Years - please use worksheet titled "DetailPriorFY".				$ -
Total Payment Due				$ -

REPORT AND PAYMENT DUE BY 5/30/2017

QUARTERLY PAYMENT AMOUN

COMMENTS:

4TH QUARTER FY 2016

	April 2017	May 2017	June 2017	TOTALS
Total Patient Days				0
Less Medicare A Days				0
Less Medicare C Days				0
Prior Qtr Adjustments @ Current Rate				0
Total Assessed Days	0	0	0	0
Current Per Diem Rate	$ 5.50	$ 5.50	$ 5.50	$ 5.50
Subtotal Payment Amount	$ -	$ -	$ -	$ -
Adjustments from Previous Fiscal Years - please use worksheet titled "DetailPriorFY".				$ -
Total Payment Due				$ -

REPORT AND PAYMENT DUE BY 8/29/2017

QUARTERLY PAYMENT AMOUN

COMMENTS:

TOTAL STATE FY 2017 QUALITY ASSESSMENT $ -